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The program at P.S. 158-M for "aphasic" children provides the proper setting (small classes, highly motivated and excellent teachers, direct supervisory instruction, and administrative support) in which to study the particular child and his capacities and incapacities. Communication and language are developed using individual and group approaches. Often related behavior problems and poor social reactions should be controlled before the child can respond to training.

After clinical diagnosis, educational evaluation is performed by the teacher; her results are stated in terms of learning needs. The teacher then begins the program, which is designed for the child's needs.

Teachers are selected for their training in basic elementary education, education of the deaf and hard of hearing, and speech pathology and education.

Methodology is drawn from current literature. Policy is then based upon the evaluation of the success of applied methods in meeting particular needs.

Special services include special teachers, counseling service, educational re-evaluation, and social and psychological services.

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Children with Language Impairments

A Special Program of the School for the Deaf at P.S. 158-M

By JOHN D. HARRINGTON
Principal

Communication between two human beings takes place through the vehicle of language, a system of symbols which represent our thoughts or the names of things. In general this relates to the use of words, phrases, and sentences in interpersonal exchange, but language also can be nonverbal. This appears fairly simple, but in actuality the concept of "language" is more complex and plays a more profound role than most of us realize—not only in the subtler considerations which arise when we discuss "communication" but in the process of education itself where, in actuality, we tend to take "language" for granted.

Abstract and concrete thinking develop not only as a result of our environment and the capacity of the intellect to interact with that environment but it develops in direct relationship to the language system which exists to represent it. Language thus helps to "shape" our experience and, in more ways than is evident, "language" shapes us into the particular persons which we become.

To develop a system of verbal and nonverbal language there must be a basic capacity to perceive, associate, store, relate and apply sensory experiences. The process of receiving sensory experience in conjunction with language is called reception. The process of thinking a thought is conceptualization and then the process of translating that thought into motor speech is called expression. A breakdown in any of these processes, in full or in part, is described as a language or communications disorder or impairment. True language disorders or impairments are organic in nature and may occur from central nervous system lesion either in association with either natal, pre-natal or post-natal conditions. Where there is language impairment due to injury to the brain or brain stem at or near the time of birth, the condition is called a congenital language disorder and may be further classified broadly as receptive or expressive. Classic descriptive literature indicates that when there is language impairment due to adventitious injury or trauma, the condition is described as "aphasia."

When the word "aphasia" is used to describe a child, however, it is generally used to indicate known or inferred birth-associated language impairment. It would seem that the only explanation for the continued inappropriate use of this term is that there is general understanding that the word "aphasia" implies a rather wide variety or continuum of language impairments currently being identified in children. In addition, we do not have a single noun term to represent the "child with a congenital language disorder." Used in its most general sense the word "aphasia" may be valuable because in its broadness it does not attempt to label a particular category of language disorder. In effect, each language-disordered child is quite different from all others—with his own particular combination of language-learning impairments depending upon the sensory or cortical functions which have been either reduced in effectiveness or rendered inoperative by brain lesion. The impairment may be identifiable (anoxia, trauma) or inferred from symptomatology.

Among "aphasic" children are those whose condition is variously described as:

1. *Expressive or motor aphasia*:
   These children hear and understand what is said at their level but are unable to put their thoughts into speech or when they attempt to speak, they produce jargon, or single words, or gesture alone.
2. *Receptive or auditory or sensory aphasia; dysacusias; agnosia; central auditory imperception*:
   These children can hear gross sound or the sound of speech but cannot react appropriately because the sound carries no meaning for them. Consequently they are either unable to speak or can only speak what they have learned or been taught to understand.

   This condition can co-exist with true peripheral hearing loss, thus

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placing the child in the category of the deaf or hard-of-hearing.

We are *not* speaking of children who are:

1. *brain-injured* The use of this term would mean that the child reflects Strauss-syndrome characteristics (distractibility, perseveration) and impaired perception. Although aphasic children frequently manifest such symptomatology, they have a much more apparent language problem as well.

2. *deaf, hard-of-hearing* This refers to peripheral reduction in acuity without a brain-injury-oriented language problem. Language retardation may occur as a result of experiential verbal deprivation but the power to learn and use language is intact and language may be achieved through visual channels, amplification and careful language instruction. Peripheral conditions can exist in conjunction with "aphasia."

3. *retarded* The "educable" or "trainable" child may have characteristics associated with language or communications disabilities but the major problem here is basic limitation in learning capacity. On the other hand fundamentally "aphasic" children not effectively examined may easily appear to belong in these categories because of language and perceptual limitations which impede the use of basic capacity. to be termed "asphasic" the child is presumed by the examiner to possess normal capacity which manifests itself unevenly in individual examination results because of the presence of the organic communications disorder.

4. *emotionally disturbed, mentally ill*

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While the presence of a language disorder may readily bring about serious emotional reaction, the "aphasic" child's inability to communicate is based in the language area rather than in the interpersonal or affective areas.

5. *speech-impaired* Speech production is basically a language problem for the "aphasic" child. While there will be many associated speech faults, these faults, such as poor articulation and delayed speech are secondary to the language impairment.
6. *cerebral-palsied* Limited ability to speak in this instance is a matter of dysarthria or motor impairment rather than one of inability to translate thoughts into motoric speech. Some cerebral palsied children may have a combination of both expressive aphasia and dysarthria.

The difficult job of distinguishing "aphasic" children from the above categories is achieved through the clinical services in each of the offices of the Bureau of Child Guidance. The evaluation for admission combines a study of the record or report from the referring agencies (speech, hearing, child evaluation agencies) and an examination of the child.

Organization and Services of the School

The School for the Deaf at P.S. 158-M is an administrative title for what actually combines a bureau for educational service to 100 deaf and hard-of-hearing children in regular schools (i.e., outside of J.H.S. 47) and a rapidly growing school for "aphasic" children.

Programs for the deaf include services to deaf infants as young as one year of age (Hunter College, Bellevue and Bronx Municipal Hospital Speech and Hearing Centers) to deaf children in Richmond (at P.S. 40), to 100 deaf students under the guidance of resource teachers of the deaf in four academic and vocational high schools, to capable deaf children who are in integrated schools and to deaf adults in special classes at Washington Irving Evening High School. These educational services to the deaf are provided by a corps of licensed teachers of the deaf assigned and supervised by the School for the Deaf at P.S. 158-M. Another large and related program is itinerant in nature and provides intensive hearing guidance and lipreading instruction to 700 hard of hearing children at over 125 lipreading centers in the regular schools. Thus the School for the Deaf at P.S. 158-M might appropriately be described as a bureau for service to the hearing impaired and a school for the

History of Program for Language Disorders

The nucleus for the present aphasic program began about fifteen years ago when Dr. William C. Barger, neuro-psychiatrist for the Bureau of Child Guidance, appealed to Miss Harriet F. McLaughlin, then principal of J.H.S. 47-M for help in educating several children "who could hear but not speak." It was felt that teachers of the deaf were conversant with the problems of language development. From its one class beginning the program has grown continuously. In 1961 the School for the Deaf at P.S. 158-M was created to administer and develop the growing aphasic program as well as the other programs which have been briefly described. At the present time these are 25 classes and 150 children in the aphasic program. New cases are being identified and referred by the Bureau of Child Guidance daily. To meet immediate needs five new classes are projected for September of 1965.

Pupil Population

Children come from schools for the deaf, from speech and hearing clinics, from suspension, from home instruction and from regular schools. It is apparent that there has been either a significant increase in the incidence of language disorders or an increase in awareness concerning the characteristics of language disorders in the process of differential diagnosis. The complexity and severity of the language disorders seen in the children being admitted is startling. In many cases there is almost no ability to communicate with the people and the environment in which the child lives. Many can understand little, many cannot speak and many have developed an array of personal and social maladaptive reactions to the severe frustration of being unable to communicate. In addition, their parents are often confused and upset and do not understand the problem.

The Program

The help that is needed and given is "education" in its most literal sense. There is as yet very little in the literature which gives guidance concerning methods for use with "aphasic" children, but the basic premise must be to provide the proper setting (small classes, highly motivated and excellent teachers, direct supervisory instruction and administrative support) in which to study the particular child and his capacities and incapacities and the channels and conditions which are most conducive to his learning. Then communication and language are developed using individual and group approaches. Often related behavior problems and poor social reactions must be controlled before the child can respond to training.

A mixture of true acceptance and care-

and lack of social control and to harness capacities which have in effect been discarded because of their frustrating ineffectiveness. If one must characterize the method used one would have to state that it amounts to "enlightened eclectic experimentalism" applied on an almost individual basis in a social (thus more effective and real) situation.

Diagnostic Teaching

Educational evaluation follows the clinical diagnosis of the Bureau of Child Guidance and the community clinics. This evaluation is achieved by the teacher through careful educational observation and the results are stated in terms of learning needs (auditory stimulation or training, visual perceptual training, language readiness, number readiness, fundamental receptive language experience, language structure and reinforcement, beginning speech, reading, elementary number concepts, visuomotor training, writing, etc.). The teacher then plans her approach; under supervision and guidance she selects her methods from the multiplicity of possible ways of achieving the selected objectives. She proceeds to check the efficacy of the approach selected by means of observing the evidences of progress or success. Such an approach requires a knowledge of the sequences of learning in the various areas and a realization of the various modes by which an organism may learn. For example, language may be developed for an expressive group (children are grouped for similar learning patterns — in general classes will be broadly homogeneous for chronological age and for language learning capacity) through a well-structured and sequential reading instruction program with special care to excellence of methodology and simplicity of approach. A receptive group (which may contain some children with peripheral and/or some with central impairment) may be taught a language program patterned after the sequences used with deaf children. A receptive group that has failed to learn language under other approaches may proceed to use the highly elemental and structured Association or McGinnis Method. It is apparent that the approach is eclectic and requires close supervisory guidance.

Teacher Development

To provide the necessary variety of professional backgrounds to support such a program teachers are sought from three main educational disciplines: basic elementary education, education of the deaf and hard of hearing, and speech pathology and education.

An intensive teacher development program under the able leadership of Mrs. Hortense Barry not only draws from these areas of competency in order to develop the staff as a whole but also provides a

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stimulation, internship training and supportive teacher education as it explores areas not yet sufficiently developed in college training programs.

Methodology

Guidance for methodology is drawn from current literature (as yet not actually research-supported) as presented to the staff by the administration of the school. Policy, where established, is then based upon the evaluation of the success of applied methods in the meeting of particular needs.

It would be most foolhardy to convey the impression that the program has established conclusively effective methodologies or that it is satisfied with its current rate of partial success. To use a worn expression we have "only begun to scratch the surface." There has been success in helping very confused and upset children to communicate; the population of the school appears to become better and better adjusted, as a group, as the school continues to grow and to mature. Nevertheless, we are becoming more and more conscious of the need to know more about teaching children who are suffering from conditions along the broad spectrum of language and language learning impairments. Of the urgent needs to be met are research (not only for the benefit of aphasics but for normal learning theory) in all areas of sensory and language learning, a defensible "in-school" visuo-motor training program, a program of pre-vocational training to prepare aphasic youths for life occupation, a highly developed program of standardized and non-standardized psychometric evaluations of language learning capacities and a research-supported clinical and therapeutic curriculum based upon diagnosed needs.

Services

The program enjoys several services but needs a great many more. The Bureau of Speech Improvement contributes the expert services of a special teacher who adds significantly to the speech program of the school. Part time guidance counseling services and Bureau of Child Guidance services are provided to assist with the large number of very complex social and psychological problems which occur in the processes of intake, in guidance and therapy, and in the eventual placement of children. Educational re-evaluation is perhaps one of the most important by-products of the program. Thus children in whom "aphasia" was predominant upon admission are subsequently seen to be "trainable," "educable," "brain-injured" (without a language problem), "deaf," or "emotionally disturbed" and thus need to be appropriately re-assigned. A neuro-psychiatric service is also needed for the effective operation of the program. More extensive social work, psychological, and psychiatric services will be necessary if the program is to grow in size or service. Curricular and health services are also needed for the effective operation of the program.

Integration into Regular Schools

Aphasic children whose language problems diminish or resolve are trained to assume their place in regular schools. Between six and ten children per school year are prepared for this placement by gradual integration into the regular classes of P.S. 158-M before their transfer to home schools. A special "integrating" teacher works with these children and their teachers to help in the transition of the now able children to regular classes at their level of ability.

While the program at P.S. 158 has earned a reputation for leadership, it is a new and somewhat primitive beginning in a most challenging and stimulating area of education.

By far the most impressive feature of the "aphasic" program is the exceptionality of the children whose power of communication with the world rests largely in the efficacy of the "education" we are able to provide.

Summary of Referral Procedures:

a. **Infant Program for Deaf** — Apply at Bellevue, Hunter College or Bronx Municipal Hospital Speech and Hearing Clinic.

b. **High School Classes for Deaf** — Admission by graduation from J.H.S. 47 or by advance application to the School for the Deaf at P.S. 158-M.

c. **Integration Program for Deaf** — Admission by selection from pupils at the Schools for the Deaf or by advance application to the School for the Deaf at P.S. 158-M.

d. **Lipreading Program (Hard of Hearing)** — Admission to the lipreading program may be effected either through a visit of child and parent to the Hearing Conservation Clinic at 225 E. 23rd Street, New York 10, N.Y. (through the child's local school) or by addressing audiological records to the principal of the child's local school with a copy to Mr. John D. Harrington, Principal of the School for the Deaf at P.S. 158M, 1458 York Avenue, New York 21, N.Y.

e. **Aphasic Program (158-M-Deaf)** — Child in school or of school age (five years old)—Refer to local Bureau of Child Guidance via principal of local school.
Children as yet ineligible for school entrance because of age (under five) —Refer to Mr. John Harrington, Principal, School for the Deaf at P.S. 158-M or to the local office of the B.C.G.

f. **School for the Deaf (J.H.S. 47)** — Admission by otologist at Hearing Conservation Clinic at 25 E. 23rd